NOAA DIVING PROGRAM
REPORT OF MEDICAL HISTORY

TO BE COMPLETED BY APPLICANT – PLEASE PRINT CLEARLY

1. Last Name	First Name	Middle Name	2. Date of Birth	3. Date

4. Home Address	a. Home Telephone Number: b. E-mail:
5. Work Address	a. Work Telephone Number: b. E-mail: c. Cell:

6. List all current medications including prescription and nonprescription.	7. List all allergies including insect stings/bites, food, medicine, other substances.

HAVE YOU EVER HAD OR DO YOU CURRENTLY HAVE –

Each item marked as "yes" must be fully explained with dates in Item 42 on page 2 by question number.

No	Yes		No	Yes	
☐	☐	8. a. Tuberculosis	☐	☐	12. a. Recent unexplained gain or loss of weight
☐	☐	b. Lived with someone who had tuberculosis	☐	☐	b. Tumor, growth, cyst, or cancer
☐	☐	c. Asthma or any breathing problems related to exercise, weather, pollens, etc.	☐	☐	13. a. Dizziness or fainting spells
☐	☐	d. Been prescribed or used an inhaler	☐	☐	b. Frequent or severe headaches
☐	☐	e. Shortness of breath or wheezing	☐	☐	c. A head injury, memory loss, or amnesia
☐	☐	f. Sinusitis, bronchitis, or frequent colds	☐	☐	d. A period of unconsciousness or concussion
☐	☐	g. Hay fever	☐	☐	e. Seizures, convulsions, epilepsy, or fits
☐	☐	9. a. Severe tooth or gum trouble	☐	☐	f. Car/train/sea/air sickness or fear of enclosed spaces
☐	☐	b. Thyroid trouble or goiter	☐	☐	g. Other neurologic disorder or injury
☐	☐	c. Eye disorder or trouble	☐	☐	14. a. Prolonged bleeding, blood clot, or embolism
☐	☐	d. Loss of vision in either eye	☐	☐	b. Pain or pressure in the chest
☐	☐	e. Ear, nose or throat trouble	☐	☐	c. Palpitation, pounding heart, or abnormal heartbeat
☐	☐	f. Hearing loss or wear a hearing aid	☐	☐	d. Heart/blood vessel surgery, murmur, other disorder
☐	☐	g. Surgery to correct vision (RK, PRK, LASIK, etc.)	☐	☐	e. High or low blood pressure
☐	☐	10. a. Painful or swollen joint(s)	☐	☐	15. a. Nervous trouble, anxiety, panic attacks
☐	☐	b. Arthritis, rheumatism, tendonitis, or bursitis	☐	☐	b. Excessive depression or worry
☐	☐	c. Recurrent back pain or any back problem	☐	☐	c. Received counseling of any type
☐	☐	d. Numbness, tingling, or sensitive area(s)	☐	☐	d. Been evaluated or treated for a mental condition
☐	☐	e. Loss of finger or toe	☐	☐	e. Attempted suicide
☐	☐	f. Foot problems	☐	☐	f. Inability to focus or pay attention
☐	☐	g. Impaired use of arms, hands, legs, or feet	☐	☐	16. Have you ever been found not medically fit for diving?
☐	☐	h. Knee trouble (locking, giving out, pain, injury, etc.)	☐	☐	17. Do you have any difficulty distinguishing colors or seeing at night?
☐	☐	i. Use of prosthetic/corrective devices, braces, supports	☐	☐	18. Are you able to perform moderate to heavy exercise without any problems?
☐	☐	j. Bone, joint, or other deformity	☐	☐	19. Do you or any of your family members have diabetes, high cholesterol, stroke, or heart disease?
☐	☐	k. Broken bone(s)	☐	☐	20. At this time do you think you might be pregnant?
☐	☐	l. Artificial joint or plates/screws/rods/pins in any bone	☐	☐	21. Have you ever been diagnosed or treated for patent foramen ovale (PFO)?
☐	☐	11. a. Frequent indigestion or heartburn	☐	☐	22. Have you ever been treated in a decompression chamber with a diving treatment table?
☐	☐	b. Stomach or intestinal trouble, colostomy or ileostomy			
☐	☐	c. Jaundice, hepatitis, or liver disease			
☐	☐	d. Rupture or hernia			
☐	☐	e. Sexually transmitted disease (syphilis, gonorrhea, Chlamydia, herpes, genital warts, other)			
☐	☐	f. Rectal disease, hemorrhoids, bleeding from rectum			
☐	☐	g. Skin disease (acne, eczema, psoriasis, etc.)			
☐	☐	h. Kidney/bladder problems, problems with urination			
☐	☐	i. High or low blood sugar			
☐	☐	j. Sugar or protein in the urine			

Clear form

Last Name	First Name	Middle Name	Date

When diving, have you ever experienced any of the following (each item marked as "yes" must be fully explained with dates in Item 42 below by question number):

No	Yes		No	Yes	
☐	☐	23. Arterial gas embolism (AGE)	☐	☐	30. Inability to equalize middle ear pressure
☐	☐	24. Oxygen toxicity	☐	☐	31. Vertigo (dizziness)
☐	☐	25. CO2 toxicity	☐	☐	32. Asphyxiation
☐	☐	26. Ear and/or sinus squeeze	☐	☐	33. Type I DCS (pain only, itching, rash, swelling)
☐	☐	27 Collapsed lung (pneumothorax) or lung squeeze	☐	☐	34. Type II DCS
☐	☐	28. Near drowning	☐	☐	35. Ear drum rupture
☐	☐	29. Loss of consciousness	☐	☐	36. Any other unusual symptoms

39. Other medical condition(s) not listed above:

40. Have you ever had or been advised to have any type of surgery or operation? ☐ No ☐ Yes
If so, specify when, where, and what was performed.

41. a. Alcohol use and frequency:	b. Tobacco use (type and frequency):	c. Illegal drug use (type and frequency):

42. Detailed explanation of all items answered "yes" with dates of occurrence. Add additional pages if necessary.

I certify that the above information supplied by me is true and complete to the best of my knowledge. I realize that omitting or misrepresenting facts called for above may be cause for refusal of diving certification.

43. _____
Signature of applicant

TO BE COMPLETED BY EXAMINER (MD/DO/NP/PA ONLY) –

44. Summarize abnormal findings and elaboration of all pertinent data.

45 . a. Examiner.	b. Name and Address of Examination Location.	c. Telephone Number.

_____
Print Name of Examiner

_____
Examiner Signature

Title (MD/DO/NP/PA only):_____